COLLEGIALITY AMONGST NURSES AND NURSE PRACTITIONERS IN THE ACUTE CARE SETTING: A NURSE'S PERSPECTIVE

by

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ABSTRACT

Healthcare is an ever changing entity. With current restructuring and projected physician shortfalls, there is a movement of nurse practitioners into the acute care setting. Little research has been done to examine nurses' perceptions of interactions with nurse practitioners in the acute care setting, and how these perceptions can influence the interpersonal dynamics of the nurse-nurse practitioner relationship. Research has shown that improved collaboration leads to improved collegiality amongst colleagues; which in turn leads to improved patient outcomes. The purpose of this descriptive study was to examine nurses' perceptions of either their observed or actual experiences regarding collaboration, and therefore collegiality, amongst the nurse practitioners they work with in the acute care setting. Additionally, this study investigated whether or not there was a difference in the level of collegiality between a Magnet designated hospital and a non-Magnet designated hospital. The sample was comprised of 222 nursing staff. The Collaboration and Satisfaction about Care Decisions survey was completed by nurses currently employed in two acute care hospitals in a city in the North West. Total collaboration scores were calculated for each participant; scores range from 0 to 56, with 0-18 being non-collaborative, 19-37 being neutral, and 35-56 being collaborative. The mean collaboration score for the sample was 36.91, showing neutral collaboration amongst nurses and nurse practitioners in the acute care setting. The data also showed that there was no difference in collaboration between a Magnet and a non-Magnet designated hospital ($0.078 > 0.05$). By identifying nursing's perceived level of collaboration, and collegiality with nurse practitioners, institutions would have a platform for which further investigation into and improvement of these relationships can take place. Improvement in the collegiality of nurses and nurse practitioners leads to benefits for both staff and patients. Of significance an unintended result of the study was that 25.3% of nurses were unaware of the difference in practice between nurse practitioners and physician assistants in the acute care setting. This gap in knowledge could have potentially negative future implications for advanced practice nursing.

CHAPTER 1

INTRODUCTION

The role of Nurse Practitioners (NPs) humbly began in 1965 (American Academy of Nurse Practitioners [AANP], 2012). Since this time the NP role has evolved and matured to accommodate an ever changing medical model. NPs have successfully provided care for patients for over 47 years (Barr, Johnston, and McConnell, 2000; Gagan and Maybee, 2011). Even today there is a need for continued evolution of this role as hospitals and clinics are being forced to restructure and cut costs due to funding concerns (Frellick, 2011). By 2015 the projected shortfall of physicians will be approximately 63,000 and there may be as many as 32 million more people attaining health insurance. A lack of physicians coupled with more persons insured and a rapidly aging population with chronic diseases has left acute care facilities needing to fill physician gaps. This has opened up opportunities for NPs to enter into areas that traditionally were once the sole domain of physicians (Frellick, 2011). In 2004 3.5% of NPs were in the acute care setting. This increased to 3.8% in 2008 (Health Resources and Services Administration, 2010, pp. 20) and to 5.6% by 2011 (AANP, 2011).

This influx of NPs in to the acute care arena has had numerous benefits for both patients and staff. However, the addition of a new team member and provider restructuring within the acute care setting has not been fully analyzed. While the relationship between health care workers is an ever evolving phenomenon (Taylor-

Seehafer, 1998; Lindeke and Sieckert, 2005), these relationships have traditionally been composed of nurses and physicians. Now these relationships are expanding to accommodate the relationship between nurses and NPs. Since there is little knowledge about the interpersonal dynamics between nursing and NPs, potential barriers to successful integration of NPs into the acute care setting cannot be identified.

Problem

There is little known about how the addition of NPs into the hospital setting is reshaping the interpersonal dynamics of the nurse-NP relationship.

Purpose

The purpose of this descriptive study was to examine nurses' perceptions of either their observed or actual experiences regarding collaboration, and therefore collegiality, amongst NPs they work with in the acute care setting.

Research Questions

1. How strong are the perceptions of nurses' observed or actual experiences regarding collaboration, and therefore collegiality, amongst the NPs they work with in the acute care setting?
2. Is there a difference in collaboration, and consequently collegiality, between nurses and NPs in a Magnet or non-Magnet designated hospital?

Background

There have been numerous studies examining the collegial relationship between different health care workers; with the majority of research being focused on the nurse-physician relationship (Taylor-Seehafer, 1998; Coeling and Cukr, 2000; Lindeke and Sieckert, 2005; Rosenstein and O'Daniel, 2005; Rosenstein, 2002; Chaboyer and Patterson, 2001; Manojlovich and DeCicco, 2011). There have been very few studies examining the relationship between nurses and NPs.

With the changing face of healthcare and an influx of NPs into the acute care setting this gap in the literature could obscure fundamental barriers to the movement of NPs into the acute care setting. It is imperative that these relationships be examined because the quality of the nurse to NP relationship directly affects patient care as well as job satisfaction (Taylor-Seehafer, 1998; Coeling and Cukr, 2000; Kramer and Schmalenberg, 2003; Rosenstein and O'Daniel, 2005; Chaboyer and Patterson, 2001; Rosenstein, 2002). A further compounding factor to the movement of NPs into the acute care setting is nursing's awareness of the difference in practice between NPs and Physicians Assistants (PAs). PAs work under physician supervision while NPs are independent practitioners; however, the recognized scope of practice does vary from state to state and facility to facility (American College of Physicians, 2010). Therefore, in some states and facilities there is physician oversight of NPs and not in others; whereas all PAs have a supervisory physician overseeing the care they provide. Thus, if nurses are not aware of or have misconceptions of the difference in practice between NPs and PAs in their state and facility, this has the potential to manifest as unmet expectations by

either nurses, NPs, or both. If nursing is not accepting of NPs, whether it be because of lack of trust, interpersonal nurse-NP dynamics, misunderstanding of the NP role, lack of collegiality, or lack of comfort in working with NPs; the movement of NPs into the acute care setting will not be successful. Identification of these barriers is a start in the process of analyzing the nurse-NP relationship. Examination of collaboration, which impacts collegiality (Collins American English Dictionary, 2012; Gooden and Jackson, 2004; and Lindeke and Sieckert, 2005), helps to construct a foundation for which potential barriers to NP movement into the acute care setting can be examined. If these barriers cannot be overcome, there could be serious ramifications in the future regarding patient care and staff retention (Dugan, Scholle, Steidle, and Goldberg, 2011).

A study by Rosenstein (2002) found that barriers between co-workers, especially with regards to collaboration, inhibits teamwork for which in turn impacts patient care by affecting safety, efficiency, and accuracy. Rosenstein (2002) also found that nurses who worked in low or no collaborative environments were less satisfied with their jobs and were more likely to leave and seek employment elsewhere. As a result of low nursing retention, there is an increased cost to the organization for recruitment and training of new nurses; as well as a fractured team which, again, leads to impaired patient outcomes and decreased satisfaction for both patients and staff (Rosenstein, 2002). Thus, it is crucial to identify these obstacles so that healthcare facilities and staff are conscious of them and can work to remedy these issues to promote the highest possible care for patients, and an enjoyable and productive work environment.

This gap in the literature has left a void in awareness of potential barriers that NPs may be faced with and need to overcome in order to make their advancement into the acute care setting successful. This study will attempt to identify the level of collegiality between nurses and NPs. It is hoped that, if there is a decreased level of collegiality present, bringing this to light would help both nurses and NPs to acknowledge the pitfalls and challenges that exist between the two professions. This then, would lead to the identification of the barriers that exist and the development of potential tools to help them overcome these barriers. Thus, this study is an attempt to lay the groundwork for future studies. By examining the views that nurses have towards NPs, both collaborative and non-collaborative, the level of collegiality can be identified. By highlighting deficiencies within the nurse-NP relationship, nurses and NPs can work together to develop coping skills to remedy these obstacles and improve relationships for current nurses and NPs; as well as future nurses and NPs. Whether the nurse-NP relationship in this study is found to be collaborative or not, the results will be useful across all organizations throughout the country.

Definition of Terms

Nurse; nursing encompasses a wide variety of educational backgrounds. There are two main categories of nursing, licensed practical nurse (LPN) and registered nurse (RN), both of which have to pass their own national certification exams. The main difference, besides length of schooling, is that LPNs practice dependently under a RN or a physician and RNs practice independently (Career Resource Network (RN), 2012; Career Resource

Network (LPN), 2012; Crosta, 2009). For this study, the term nurse will refer to either RNs and/or LPNs. Thus, throughout this study the term nurse will be used to imply all levels of nursing, LPNs and RNs.

Nurse Practitioner; NP includes nurses that have achieved advance practice education at either a master's level or doctoral level (American Association of Nurse Practitioners [AANP], 2013). There are many different specialties that NPs reside in. The term NP will encompass all NPs who practice in the acute care setting, regardless of their specialty.

Collaboration; a collaborative relationship is defined as "good" or "great" (Kramer and Schmalenberg, 2003) It embodies mutual trust, respect, and willing cooperation amongst individuals (Kramer and Schmalenberg, 2003). With collaboration; there is knowledge sharing, open and effective lines of communication, joint decision making/consensus, and an appreciation for what each individual contributes (Lindeke and Sieckert, 2005). Colleagues work together toward common goals: providing excellent patient care and creating supportive, healthy work environments (Lindeke and Sieckert, 2005). Therefore, for the purposes of this study, collaboration is defined as this type of relationship that exists amongst colleagues. Collaboration will be measured using the Collaboration and Satisfaction about Care Decisions (CSAD) questionnaire developed by Judith Baggs (1993) and categorized as collaborative, neutral, or non-collaborative.

Collegiality; According to the Collins American English Dictionary (2012), collegiality is defined as "the sharing of authority among colleagues" (Definitions, para.

1). Because collaboration involves sharing of information and joint decision making, it can be inferred that an increased level of collaboration results in an increased level of collegiality. Therefore, for the purposes of this study collegiality will be inferred as a secondary gain to collaboration. Thus, an increased collaboration results in increased collegiality and decreased collaboration results in decreased collegiality.

Theoretical Framework

The theoretical framework used in this study is from the Thomas conceptual model of collaboration (1976). This model identifies five conflict handling modes. Thomas (1992) describes these five modes as existing on a continuum between two underlying dimensions of assertiveness and cooperativeness. Collaboration has the highest degree of both assertiveness and cooperativeness (Weiss and Davis, 1985). As depicted in figure 1, all four modes, excluding collaboration, are not ideal modes of interpersonal problem solving behaviors (Thomas, 1992).

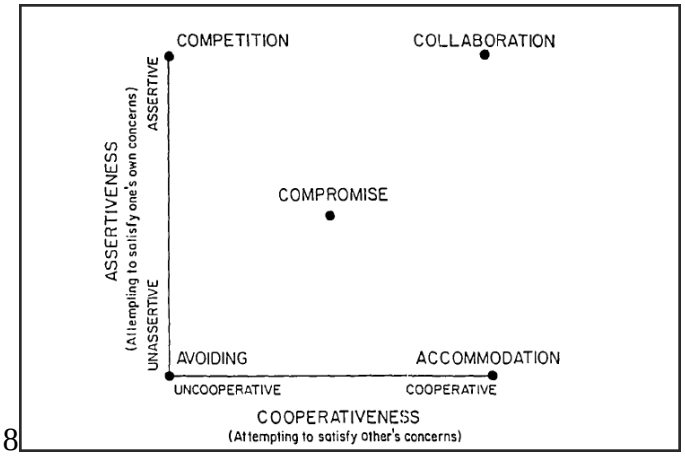

Figure 1. Thomas Conceptual Model of Collaboration (1976).

According to Weiss and Davis (1985), “collaboration involves attempts to find integrative solutions where both parties’ concerns are recognized and important concerns are not compromised. It merges the insights of differing perspectives, and consensus is gained among those involved in the problem-solving effort through examination and working through of reservations regarding particular aspects of the decision” (pp. 299-300). Thus collaboration is the greatest outcome of interpersonal problem solving behaviors. Because collaboration is a merging of ideas and sharing of information to formulate a combined decision, it is the hallmark decision making mode for health care workers. This is because collaboration results in optimal patient care and favorable work environments (Weiss and Davis, 1985).

Thomas (1992) believes that managing conflicts in organizations without attempting to achieve collaboration is a short-term solution. To effectively manage current and future conflicts and to promote a healthy work environment, collaboration is needed (Thomas, 1992). Collaboration needs to be both an individual and organizational goal (Thomas, 1992). By embracing collaboration long-term conflict resolutions can be achieved and beneficial interpersonal relationships can be fostered. Thomas (1992) speculates that organizations can adopt and support the idea of collaboration, by providing people with the opportunity to obtain tools for effective collaboration skills, and by setting a precedent for collaboration. If people do not have the proper tools for collaboration, they will turn to competition of compromise to achieve conflict management; this promotes distrust and insufficient problem solving skills (Thomas,

1992). Also, Thomas (1992) noted that successful conflict management though collaboration requires organizational leaders to model this behavior.

Collaboration is an integral part of not just the work environment but for people themselves, as it fosters self-esteem, satisfaction, respect, affection, and trust (Thomas, 1992). All of these positively influence the work environment, attitudes, and relationships, solidifying its importance in interpersonal relationships of co-workers. Thus, for all the before mentioned qualities, the Thomas conceptual model of collaboration is the theoretical framework for which this study is based.

Summary

The literature supports that there are differences in the relationships between physicians and nurses, and ineffective communication and lack of a collegial relationship can have far reaching consequences, both for patients and staff. There has been a very scant amount of literature done to examine the relationship of nurses and NPs. There is a pressing need to examine this relationship as the face of healthcare is changing rapidly. Identification and examination of the level of collegiality perceived by nursing is one small step towards examining the complexities of the nurse-NP relationship and what obstacles need to be overcome. This research study aims to identify one side of the nurse-NP relationship, that of nursing, in order to identify whether or not collegial relationships exist; as perceived by nurses, with regards to NPs working in the hospital. It is important to achieve and maintain collegial communication between different health care groups as

the level and type of communication has been linked with patient outcomes, length of stay, and cost.

CHAPTER 2

REVIEW OF LITURATURE

Introduction

Collaboration is an essential, complex component of health care (Lindeke and Sieckert, 2005). A collaborative relationship implies a sense of trust and respect between colleagues, a combined movement towards a common goal, knowledge sharing between colleagues, and joint decision making; all resulting in a healthy, productive, nurturing relationship in which both patients and staff benefit (Kramer and Schmalenberg, 2003; Lindeke and Sieckert, 2005; Coeling and Cukr, 2000; Rosenstein and O'Daniel, 2005; Rosenstein, 2002; Chaboyer and Patterson, 2001; Manojlovich and DeCicco, 2011). Collaborative relationships can be difficult to achieve due to differences in communication styles of co-workers, different educational backgrounds, and the hierarchical relationship that exists amongst health care workers. One of the most frequently analyzed relationships is that of the nurse and the physician; however, there have also been studies regarding the physician-nurse practitioner (NP) relationship. But, there have been very few studies examining the nurse-NP relationship (Gooden and Jackson, 2004). Because little is known regarding the nurse-NP relationship; the other previously examined relationships will be reviewed. This will serve to establish a basis for the differing dynamics between various professions that exist within a health care organization.

All health care workers play a pivotal role in patient care. Nurses have intimate detailed knowledge regarding their patients which, when combined with other disciplines, helps to complete the patient's clinical picture. Thus, collaboration amongst healthcare disciplines is essential to providing quality patient care and creating healthy work environments. Domination by any one group or person could reduce collaboration and diminish positive patient outcomes and colleague satisfaction. Additionally, when collaborative relationships are fostered between co-workers, unmet expectations are reduced, support networks are formed, and as a result job stress is reduced (Lait and Wallace, 2002). This is an especially important factor in health care where emotional taxation often occurs and early burnout is a potential (Lait and Wallace, 2002).

The Hierarchical Relationship in Health Care

This continued power inequity amongst physicians and nurses is in part due to historical implications of gender, with the majority of nursing being female and the majority of physicians being male (Lindeke and Sieckert, 2005; Speed and Luker, 2006). Speed and Luker (2006) also argue that, "[…] nurses and doctors are trained within a hospital structure, nurses are socialized into a subordinate position from the outset of their careers" (pp. 885). Furthermore, physicians are considered the primary income for hospitals, and although nursing remains an important contributor to that income, their perceived lesser financial contribution lends to increased physician power (Lindeke and Sieckert, 2005). However, over the last several decades, increased collaboration and mutual respect for each other's disciplines has enabled both nursing and physicians to

focus less on themselves individually and more on the patient. This increase in collaboration has resulted in more favorable outcomes for patients and lessened the focus on the struggle for power and position (Taylor-Seehafer, 1998).

Manojlovich and DeCicco (2011) examined work environments and nurse-physician communication and collaboration. This study found that nurses who practiced in Magnet hospitals had more collaboration with physicians than did nurses at non-Magnet hospitals (Manojlovich and DeCicco, 2011). The conceptual model that Magnet hospitals follow empowers and supports nursing; as well as facilitates collaboration between co-workers (Manojlovich and DeCicco, 2011). Thus, there are many different factors affecting the hierarchical relationship in health care; but regardless, the hierarchy remains to some degree.

Nurse-Physician Relationships

Nursing and medicine began their evolutions separately from each other (Taylor-Seehafer, 1998), and continued to evolve apart, rather than together. This was in part due to nursing's desire to develop autonomy (Taylor-Seehafer, 1998). In the 1960's, the idea of nursing and medicine collaborating was viewed as something that would suppress nursing's autonomy and as a result was not pursued. Additionally, at this time, medicine was not accustomed to sharing patient care responsibilities and working collaboratively with nursing (Taylor-Seehafer, 1998). However, in the 1970's and 1980's there was a change in thinking and a movement towards collaboration was fostered. By the 1990's, through continued analysis of this topic, it was more evident how collaboration had direct

effects on patient care (Taylor-Seehafer, 1998). Despite this persistent enlightenment both physicians and nurses continue to support a relationship that consists of unequal power, although overall, there is more collaboration between nurses and physicians than previously (Taylor-Seehafer, 1998).

The nurse-physician relationship has implications not only for job satisfaction but for patient outcome also. There have been numerous studies showing that collaboration amongst nurses and physicians leads to increased nurse satisfaction, improved patient outcomes, and decreased cost of health care (Coeling and Cukr, 2000; Lindeke and Sieckert, 2005; Rosenstein and O'Daniel, 2005; Rosenstein, 2002; Chaboyer and Patterson, 2001; Manojlovich and DeCicco, 2011).

Nurses and physicians have different styles of communication. Nurses are often focused on a consensus whereas physicians are often focused on justice issues and ruling out alternatives (Lindeke and Sieckert, 2005). Additionally, nurses tend to be more holistic in their information gathering process while physicians tend to gather information in a more problem specific manner (Lindeke and Sieckert, 2005). A study by Coeling and Cukr (2000); identified three aspects, quality of care, nurse satisfaction, and collaboration, as an essential triad that enhances patient care (Coeling and Cukr, 2000). Physicians are not solely to blame for communication and collaboration failures, nursing too can have disruptive behaviors that can affect collaboration and create stressful environments (Rosenstein and O'Daniel, 2005; Rosenstein, 2002). Just as some physicians do, some nurses can also exhibit an air of professional superiority which

makes communication and collaboration difficult for all those who work with these individuals (Rosenstein and O'Daniel, 2005; Rosenstein, 2002). In fact, some co-workers will go out of their way to avoid these people, which further decreases communication and collaboration (Rosenstein and O'Daniel, 2005).

Physician-Nurse Practitioner Relationships

Since the introduction of NPs into the health care arena there had been an ever evolving relationship taking place. This relationship is uniquely different from that of nursing, as NPs are taking on duties that were once solely reserved for physicians. Thus, NPs are taking on an authoritative position that is not as subordinate as the traditional nurse-physician relationship. This can create tension amongst practitioners and can directly influence collaboration (Fleming and Carberry, 2011). Because NPs are able to perform some tasks that were once the responsibility of physicians, some physicians view NPs as a threat to their practice and potential earnings (Fletcher, Baker, Copland, Reeves, and Lowery, 2007). However, if collaboration between NPs and physicians is fostered, the results are positive patient outcomes such as: improved disease management, a superior continuum of care, and enhanced patient satisfaction (Fletcher et al., 2007; Wilson, Coulon, Hillege, and Swann, 2005; Wilson, Pearson, and Hassey, 2002).

Also, because NPs and physicians are schooled differently, they often exhibit different communication patterns. NPs are often concerned with identifying care gaps and providing holistic services (Wilson et al., 2002). Lawson (2002) found that physicians are more informational in their communication styles, and they can often take on a

controlling tone when trying to convey information. Overall, physicians had a more authoritative way of communicating as opposed to NPs (Lawson, 2002). NPs tend to allow others to have more input and actively participate in decision making (Lawson, 2002). NPs communicate in an open way facilitating conversation rather than information delivery (Lawson, 2002). Conversely, Berry (2009) found that NPs embodied a communication style akin to physicians. Berry (2009) found that the NPs in this study used a provider-centered communication style verses a patient-centered communication style. Although, it is important to note that the NPs' schedules did not give them time for patient-centered care; this push for productivity could explain why several NPs in this study were using provider-centered communication styles (Berry, 2009).

Nurse-Nurse Practitioner Relationships

The nurse-NP relationship has very unique characteristics when compared to other relationships. What makes this relationship unique is that NPs, unlike other disciplines, share several common features with nursing. NPs possess inside knowledge of nursing practice. Because of this shared upbringing, they have the potential to more easily relate to and empathize with nursing. Thus, there is an increased probability for collaboration between nursing and NPs. Additionally, because NPs reside in a grey area between the nursing world and the medical world; they are in a unique position to act as a liaison between nurses and physicians (Shebesta, Cook, Rickets, Schweer, Brown, Garcia, Falcone, 2006).

There are very few studies examining the relationships between nurses and NPs. Shebesta, et al. (2006), found that bedside nurses were more satisfied with care provided by NPs than resident physicians. The study cited not only nursing satisfaction with care provided, but also increased satisfaction with communication (both with family and nursing), human qualities, and response time as well (Shebesta, et al., 2006). McMullen, Alexander, Bourgeois, and Goodman (2001) also found that nursing scored NPs higher than physicians in several different areas, these were: NPs were willing to teach staff, patients, and family; were attentive and courteous to co-workers; respected nursing's opinions; made themselves readily available for questions or concerns from nursing; demonstrated effective communication (oral and written); had sound clinical expertise; and provided high quality care. Overall, this study found that nurses and NPs have a successfully collaborative relationship with each other; and the nurses in this study felt a sense of collegiality and satisfaction in working with NPs (McMullen et al., 2006).

Examination of the relationship between nurses and NPs revealed that nurses felt the role of NPs was both necessary and helpful; and that overall NPs are a positive contribution to health care (Gooden and Jackson, 2004). The majority nurses evaluated felt as if NPs viewed them as colleagues, they were comfortable asking questions and seeking advice from NPs, they felt that NPs were a good resource, and that NPs were easily accessible (Gooden and Jackson, 2004). Overall, nurses were satisfied with NPs. However, some nurses felt that NPs did not fully understand the role of nursing and because of this, NPs had limited respect for nurses (Gooden and Jackson, 2004).

Summary

Despite the many differences between professions; studies amongst differing professions have shown that collaboration can bridge the gap and provide people with greater job satisfaction as well as improve patient outcomes. Thus, collaboration is an essential component of healthcare because all parties benefit when there is collaboration. Despite the length of time that NPs have been practicing there have been few studies examining their relationships with nursing in the acute care setting. As more NPs move into this setting, it is essential that the potential barriers between nurses and NPs are identified. By identifying existing deficiencies in collaboration, and therefore collegiality, hospitals can take action to identify and address these issues and develop solutions. This will ensure that hierarchical relationships do not form, collaboration flows freely, and collegiality is fostered.

CHAPTER 3

METHODOLOGY

Study Design

The purpose of this descriptive study was to examine nurses' perceptions of either their observed or actual experiences regarding collaboration, and therefore collegiality, amongst nurse practitioners (NPs) they work with in the acute care setting. There have been few studies examining this topic, for this reason a basic level of study is warranted. This study will help describe the opinions of nursing towards NPs, and as a result, it will help set the foundation for which other more intricate studies can be conducted.

Setting

The setting was two acute care hospitals in a city in the North West. Hospital A is a Magnet accredited, 272 bed non-profit facility governed by the community. Their provider network includes over 320 physician and non-physician providers. Hospital B is a 286 bed non-profit facility that is funded by the Sisters of Charity of Leavenworth Health Systems. This facility is a not a Magnet accredited facility, and employees over 222 physician and non-physician providers. The hospital areas that were asked to participate in the survey include:

- Hospital A: operating room (OR)/pre-admission testing (PAT lab), intensive care unit (ICU), ambulatory telemetry unit (ATU), emergency department (ED),

inpatient cancer center (ICC), family birth center (FBC), resource pool, inpatient medical floor (IPM), inpatient surgical floor (IPS), and psychiatric center.

- Hospital B: emergency department (ED), operating room (OR), intensive care unit (ICU), inpatient medical/oncology, inpatient cardiac, inpatient orthopedics, inpatient neurology, resource pool and inpatient general surgery.

Sample

Utilizing a purposive sampling system, the target group for the research was nurses that work in either Hospital A or Hospital B on any of the before mentioned acute care floors, and were present during the survey time.

Inclusion Criteria

Nurses included in this study were willing to participate and may be either full time or part time. The nurses included in this study were those that have had actual interactions with NPs. Also included were those nurses who may not have worked directly with NPs but have perceptions about interacting with NPs. Therefore all nursing personnel were included in this study. This incorporated: registered nurses, licensed practical nurses, nurse administrators, and other nursing staff (admission/discharge/transfer [ADT] nurse, clinical supervisors, nursing quality, and nursing education).

Exclusion Criteria

Excluded from this study were any medical or non-medical personnel who were not designated under the title of nursing. Also excluded from the study were those nurses who chose not to participate and those who were not present during the survey period.

Data Collection Procedures

Protection of Human Subjects

IRB Approval was Obtained: This study was approved by the Institutional Review Board at Montana State University (MSU IRB), as well as the surveyed city's Institutional Review Board under the delineation of exempt (see Appendices A and B respectively). Verbal approval for this study was additionally obtained through Hospital A's Nursing Research Council.

Permission to Conduct the Study: Permission to survey each department was approved by each department's manager. Informed consent was implied by participation in the survey. Each survey also included a cover letter explaining the purpose of the study, the right to refuse to participate, and that participation implies consent. Confidentiality of the participants was protected by no identification of participants on the survey forms. Access to the surveys was restricted to the primary researcher and hospital staff participating in the data collection.

Survey Collection

Survey collection started in June 2012 and continued through September 2012. The survey required approximately 5-10 minutes to complete. The survey tool included a demographic questionnaire and a questionnaire about collaboration and satisfaction with NPs (see Appendices C and D respectively). Also provided for the participants was a cover letter detailing the specifics of the study (see Appendix E). Depending on each unit's preference, the researcher distributed the surveys in the following two manners.

First Method: One method included attending staff meetings for each participating acute care unit. The researcher would verbally present the purpose of the study, specify that participation was voluntary, and remind participants not to identify themselves on the survey. The surveys were then distributed to each nursing staff member along with a detailed cover letter. A blank manila envelope was left in the room for survey collection and the researcher left the room while participants were filling out the surveys. Upon completion of the surveys a selected member at the meeting would present the sealed manila envelope to the researcher.

Second Method: A second method used was for those units who did not conduct routine staff meetings. In these cases the researcher would have the manager send an e-mail out to all nursing staff members informing them of the survey, where it would be located, the length of time the survey would be available (determined by each units manager), what the survey's purpose was, that participation was voluntary, and asking for those to participate in the study that are willing. The researcher would then place the

surveys and cover letters in the designated location, during the specified survey time period. A manila envelope was left for survey collection, this envelope would have a cover letter attached to the front so that it could be identified as the envelope to return completed surveys to; additionally it was titled “return surveys here” to help alleviate any confusion. Once the specified survey period had elapsed the researcher returned and collected the envelope, as well as any remaining surveys and cover letters.

Instruments

Demographic Information

Collected demographic information included questions about length of time in nursing, current area of practice and hospital, current staff position, frequency of working with NPs, highest level of education, and awareness of differences between NPs and physicians assistants in the acute care setting (see Appendix C).

Collaboration and Satisfaction about Care Decisions

Nurses’ perspectives regarding the level of collaboration between nurses and NPs in the acute care setting were collected using the Collaboration and Satisfaction about Care Decisions (CSACD) instrument (see Appendix D). This instrument was designed and extensively tested by Judith Baggs (1993). This tool was chosen for the study because it is designed to measure collaboration amongst healthcare personnel. However, it has specifically been used to study the nurse-physician relationship.

The CSACD instrument was reviewed by 12 experts in nursing and medicine (Baggs, 1993). This instrument has undergone multiple tests of validity and internal

consistency. Criterion related validity was r=0.87, and factor loading of the instrument ranged from 0.82 – 0.93 (Baggs, 1993). Cronbach's alpha 0.93, and the inter-item correlations ranged from 0.52 – 0.83 (Baggs, 1993). Thus, the instrument has internal consistency, reliability, and validity.

Permission to use the tool and assistance with tool modification was obtained from Dr. Judith Baggs (see Appendix F). Modifications to the instrument include: changing the word physician to nurse practitioner (NP), changing of the word floor to unit, and removal of question number nine completely as it gathered an overall opinion of the hospital not of working with NPs.

This eight item tool measures collaboration between nurses and NPs with a Likert scale for frequency and agreement. The Likert scale is based on a 1-7 range with 1 being strongly disagree and 7 being strongly agree. A score of 0 was taken to indicate that the nurse had not had any previous interactions or perception of interactions with NPs, and therefore essentially had no opinion as to the degree of collaboration between nurses and NPs. Scores range from 0 to 56; with 0-18 being non-collaborative, 19-37 being neutral, and 38-56 being collaborative.

Data Analysis

Data analysis was conducted by the researcher. Access to the data during analysis was also limited to the researcher. Data were analyzed using the SPSS student version 18.

Demographic information is presented in a table format. These data include length of time in nursing, care area and hospital worked in, level of practice, highest degree

attained, frequency worked with a NP, and awareness of the difference between NPs and physician assistants. The CSACD frequency and total scores were used to answer the following research question: How strong are the perceptions of nurses' observed or actual experiences regarding collaboration, and therefore collegiality, amongst the NPs they work with in the acute care setting? The data was also examined using a t-test to compare scores between each hospital to answer the second research question: Is there a difference in collaboration, and consequently collegiality, between nurses and NPs in a Magnet or non-Magnate designated hospital? An additional ANOVA analysis was used to examine whether or not there is a difference in collaboration and collegiality between differing nursing positions.

Summary

Permission to conduct this study was obtained from the MSU IRB, the surveyed city's IRB, and Hospital A's Nursing Research council. The study began in June 2012 and was conducted through September 2012. Participants were identified using the inclusion and exclusion criteria identified previously. The final sample was determined and the data were analyzed to identify the degree of collaboration between nurses and NPs in the acute care setting, whether or not there was a difference in collaboration between a Magnet or non-Magnet hospital, and whether or not different nursing positions had any dissimilarity in levels of collaboration between them. SPSS student version 18 was used for all statistical calculations and analysis.

CHAPTER 4

RESULTS

Introduction

This study's purpose was to examine nurses' perceptions of either their observed or actual experiences regarding collaboration, and therefore collegiality, amongst nurse practitioners (NPs) they work with in the acute care setting. It was also this study's intent to examine whether or not there exists a difference in perceived collegiality between a Magnet verses a non-Magnet hospital by analyzing and comparing collaboration scores. Responses were obtained from nurses currently practicing in one of two hospitals, Hospital A and Hospital B.

Demographics

In total there were 222 nursing staff members who responded to the survey. Demographic questions included length of time in nursing, area currently employed, nursing position currently held, highest level of education completed, frequency of working with NPs, hospital currently employed, and awareness of a difference between NPs and physician assistants (PAs).

Length of time in nursing was divided into four categories: less than 1 year, 1-5 years, 5-10 years, and greater than 10 years. The majority of respondents have worked greater than 10 years in nursing (n=95, 42.8%). Results from the other listed durations of

nursing included: less than 1 year (n=19, 8.6%), 1-5 years (n=60, 27%), and 5-10 years (n=48, 21.6%) (see Table 1). There were ten different acute care areas that were surveyed between the two hospitals. Those units surveyed included: inpatient medical, inpatient surgical, inpatient intensive care unit, emergency room, operating room/pre-admission testing, inpatient oncology, inpatient cardiac/ambulatory telemetry unit, inpatient psychiatric unit, inpatient family birth center, and inpatient medical/oncology. The greatest level of participation came from the inpatient intensive care unit (n=37, 16.7%). Results from other areas included: inpatient medical (n=23, 10.4%), inpatient surgical (n=31, 14%), emergency room (n=32, 14.4%), operating room/pre-admission testing (n=5, 2.3%), inpatient oncology (n=27, 12.2%), inpatient cardiology/ambulatory telemetry unit (n=34, 15.3%), inpatient psychiatric unit (n=14, 6.3%), inpatient family birth center (n=9, 4.1%), and inpatient medical/oncology unit (n=10, 4.5%) (see Table 2). Of the total responses, the majority of participation came from Hospital A (n=162, 73%) verses Hospital B (n=60, 27%).

Table 1. Length of Time in Nursing by Number and Percent

Length of time in nursing	n	Percent
Less than 1 year	19	8.6%
1-5 years	60	27%
5-10 years	48	21.6%
Greater than 10 years	95	42.8%

Table 2. Current Area of Practice by Number and Percent

Current Area of Practice	n	Percent
Inpatient Medical	23	10.4%
Inpatient Surgical	31	14%
Inpatient Intensive Care Unit	37	16.7%
Emergency Room	32	14.4%
Operating Room/Pre-Admission Testing	5	2.3%
Inpatient Oncology	27	12.2%
Inpatient Cardiology/Ambulatory Telemetry Unit	34	15.3%
Inpatient Psychiatric Unit	14	6.3%
Inpatient Family Birth Center	9	4.1%
Inpatient Medical/Oncology Unit	10	4.5%

There were five listed positions in the demographic survey. These were: registered nurse staff (RN staff), registered nurse administration (RN administration), licensed practicing nurse (LPN), nurse practitioner (NP), and other (please specify). Of the nurses that were surveyed, the majority of positions held were those of staff registered nurses (n=198, 89.2%). Results from the other nursing positions surveyed included: RN administration (n=12, 5.4%), LPN (n=7, 3.2%), NP (n=0, 0%), and other (n=5, 2.3%) (see Table 3). The other reported positions included: nursing quality, clinical supervisor, clinical nurse specialist, nursing educator, and admission/discharge/transfer registered nurse. The highest level of education that was reported was a bachelor's degree (n=158, 71.5%). Other reported education levels included: diploma (n=10, 4.5%), associate's

degree (n=46, 20.8%), master's degree (n=7, 3.2%), and doctorate degree (n=0, 0%) (see Table 4).

Table 3. Current Nursing Position by Number and Percent

Current Nursing Position	n	Percent
RN staff	198	89.2%
RN administration	12	5.4%
LPN	7	3.2%
NP	0	0%
Other	5	2.3%

Table 4. Highest Level of Education Completed by Number and Percent

Highest Level of Education Completed	n	Percent
Diploma	10	4.5%
Associates degree	46	20.8%
Bachelor's degree	158	71.5%
Master's degree	7	3.2%
Doctorate degree	0	0%

There were four options presented for the frequency of interactions between nurses and NPs. The listed options were: never, rarely, frequently, and very frequently. The majority of surveyed nurses report that they frequently work with NPs (n=88, 39.6%). Other reported frequencies included: never (n=25, 11.3%), rarely (n=74, 33.3%), and very frequently (n=35, 15.8%) (see Table 5). Of the nurses that were surveyed the majority were aware of the difference in practice between NPs and PAs (n=166, 74.8%) verses those that were not aware of the difference (n=56, 25.3%) (see Table 6).

Table 5. Frequency Worked with Nurse Practitioners in the Acute Care Setting by Number and Percent

Frequency Worked with NPs	n	Percent
Never	25	11.3%
Rarely	74	33.3%
Frequently	88	39.6%
Very Frequently	35	15.8%

Table 6. Awareness of Difference between Nurse Practitioners and Physician Assistants by Number and Percent

Awareness of Difference Between NPs and PAs	n	Percent
Aware of difference	166	74.8%
Not aware of difference	56	25.3%

CSACD Results

Collaboration scores were analyzed according to mean, median, mode, standard deviation, and variance based on responses (n=222) to the Collaboration and Satisfaction about Care Decisions (CSACD) questionnaire. The reported CSACD scores were totaled for each survey, these scores ranged from 0-56. Individual question analysis was performed on each of the each of the questions comprising the CSACD questionnaire. The mean, standard deviation, and variance were calculated for each of the eight questions (see Table 7). Furthermore, the frequency, percent, valid percent, and cumulative percent for each CSACD questionnaire were also examined (see Table 8). The data was further statistically examined by hospital to ascertain whether or not there was a statistical difference between a Magnet and a non-Magnet hospital (see Table 9).

Collaboration Scores

Collaboration scores were used to determine how strongly the surveyed nurses perceived their collaboration with NPs in the acute care setting. The mean collaboration score was 36.91, the median score was 40.5, and the standard deviation was 16.34. Therefore, the surveyed nurses felt neutral regarding collaboration with NPs in the acute care setting. Further analysis was performed on each question in the CSACD questionnaire. The mean scores for each of the 8 questions range from 4.96 to 5.44 with a standard deviation range of 1.42 to 1.57 (see Table 7). Therefore, the majority of the responses to the individual CSACD questions fell in a neutral category; that is less than strongly agree and more than strongly disagree.

Table 8 reports the range of scores, frequency, response percent, and valid percent of each CSACD questionnaire. The top three most often reported scores for the CSACD questionnaire were: 0.0 (n=23, 1.8%), 56 (n=17, 1.3%), and 48 (n=15, 1.1%). Although, two of the highest scores fell within the collaborative category (38-56) and the largest number of responses were within the collaborative category; the large percentage of no responses (0.0, n=23) did bring the overall collaborative score down to a neutral category (36.91) (see Table 8).

Table 7. Collaboration and Satisfaction about Care Decisions (CSACD) Individual Question Analysis

Question	n	Scoring Range	Mean	Standard Deviation	Variance
Nurses and NPs planning together about care decisions	199	0-7	5.05	1.57	2.5
Open communication between nurses and NPs about patient care decisions	199	0-7	5.44	1.42	2.03
Shared decision making responsibilities between nurses and NPs	199	0-7	4.96	1.53	2.35
Nurses and NPs cooperate in making decisions about patient care	199	0-7	5.20	1.48	2.18
Concerns of both nurses and NPs are considered when making patient care decisions	199	0-7	5.31	1.45	2.11
Decision making is coordinated between nurses and NPs	197	0-7	4.98	1.52	2.32
Level of collaboration that takes place between nurses and NPs when making patient care decisions	199	0-7	5.00	1.48	2.20
Overall satisfaction of collaboration between nurses and NPs	197	0-7	5.34	1.45	2.11

Table 8. Frequency of Responses to the CSACD Questionnaire

Level of Collaboration	Scoring Range	n	Response Percent	Valid Percent
Non-Collaborative	0-18	30	2.4	13.7
Neutral	19-37	61	4.9	28
Collaborative	38-56	131	10.1	59.4

Collaboration Differences between a Magnet Hospital Verses a Non-Magnet Hospital

The data was further analyzed using a t-test to determine whether or not there was a difference in collaboration between nurses and NPs in a Magnet verses a non-Magnet designated hospital. This data is represented in Table 9. The reported 2-tailed significance value of 0.078 showed that there was no statistical difference found in the level of collaboration amongst nurses and NPs in a Magnet verses a non-Magnet hospital (0.078 > 0.05) (see Table 9). Therefore, between the two surveyed hospitals there was no greater degree of collaboration in the Magnet designated hospital (Hospital A) than in the non-Magnet designated hospital (Hospital B).

Table 9. Difference in Collaboration between a Magnet Hospital Verses a Non-Magnet Hospital

	t	df	Sig. (2-tailed)	Mean Difference	Standard Error Difference	95% Confidence Interval of the Difference	
						Lower	Upper
Equal variances assumed (p=0.05)	-1.768	220	0.078	-4.347	2.46	-9.19	0.498

Summary

This chapter discussed the results of 222 surveyed nurses regarding their actual and perceived level of collaboration with NPs using the Collaboration and Satisfaction about Care Decisions (CSACD) questionnaire. A demographic description of the participants was provided including: length of time in nursing, area currently employed, nursing position currently held, highest level of education completed, frequency of

working with NPs, hospital currently employed, and awareness of a difference between NPs and physician assistants (PAs). The results of the CSACD questionnaire were also reported in this chapter. Further examination of the CSACD results included a t-test examination of the difference in collaboration between a Magnet hospital and a non-Magnet hospital.

In summary, the results of the CSACD questionnaire revealed that overall the surveyed nurses felt that there was a neutral level of actual and perceived collaboration between nurses and NPs. Examination of a Magnet accredited hospital verses a non-Magnet accredited hospital revealed no statistical difference between surveyed nurses' perceived or actual level of collaboration between nurses and NPs between the two hospitals. These results are discussed further in the next chapter.

CHAPTER 5

DISCUSSION

The intent of this study was to examine the perceived degree of collegiality felt by nurses regarding their working relationship with nurse practitioners (NPs) in the acute care setting. This level of collegiality was examined by using the Collaboration and Satisfaction about Care Decisions (CSACD) questionnaire. It is reasonable to assume that a greater level of collaboration would result in a greater level of collegiality amongst nurses and NPs. A descriptive design was used with a convenience sample of 222 nurses employed in two distinct but comparable hospitals in the North West. This chapter will discuss the findings of this study in relation to the research questions and theoretical framework used. Strengths and limitations of the study will be discussed. Implications for nursing practice and education as well as recommendation for future research will conclude this chapter.

Discussion of Findings

Research Question 1

The first research question addressed in this study was, “How strong are the perceptions of nurses’ observed or actual experiences regarding collaboration, and therefore collegiality, amongst the NPs they work with in the acute care setting?” The results of the CSACD show a mean collaboration score of 36.91, indicating a neutral

level of collaboration. The CSACD questionnaire was designed by Judith Baggs (1993) to examine the relationship between nurses and physicians. Therefore, it has never been used to examine the relationship between nurses and NPs, and as a result there is no data using this instrument in this manner to compare this study to.

An extensive literature review revealed very few published examinations of nursing's opinion of the nurse-NP relationship. One study conducted by Gooden and Jackson (2004) found that nurses felt the role of NPs was both necessary and helpful; and that overall NPs are a positive contribution to health care. Additionally, the researchers found that the majority of nurses felt that the NPs viewed them as colleagues (Gooden and Jackson, 2004). A study done by McMullen, Alexander, Bourgeois, and Goodman (2001) concluded that nurses and NPs have a successfully collaborative relationship with each other; and the nurses in their study felt a sense of collegiality and satisfaction in working with NPs. These studies, though they parallel the idea of examining the nurse-NP relationship, they do not actually quantify the level of collegiality between nurses and NPs. Nor do they specifically examine the nurse-NP relationship in the acute care setting. Therefore a comparison of the results of these studies cannot be made directly with the results of this study. However, in contrast to the nurses surveyed in Gooden and Jackson's (2004) study and McMullen, Alexander, Bourgeois, and Goodman's (2001) study; the nurses in this study felt a neutral level of collegiality towards the nurse-NP relationship.

There are several possible reasons for the neutral level of collegiality reported in this study. There were 25 nurses (11.3%) who reported never having worked with NPs in

the acute care setting and 74 nurses (33.3%) reported rarely working with NPs in the acute care setting. Therefore almost half of the nurses surveyed had no or rare experience working with NPs. Therefore, the nurses that were surveyed may have had only a single encounter to base their opinion on. The exact number of NPs that the surveyed nurses worked with was not included in the demographic questionnaire. Additionally, 23 of the CSACD questionnaires were returned without being filled out. This score of 0.0 did lower the mean CSACD score. Yet another possible explanation for the difference in collegiality between this study and previously published studies is that the CSACD questionnaire did not delineate between nurses' actual verses perceived experiences with NPs. Had a distinction been made between actual verses perceived collaboration the results may have been different.

Research Question 2

The second research question that this study addressed was, "Is there a difference in the collegiality, and consequently collegiality, between nurses and NPs in a Magnet designated hospital verses a non-Magnate designated hospital?" This study found no statistical difference in the level of collegiality felt by nurses about the nurse-NP relationship between a Magnet hospital and a non-Magnet hospital. Therefore, this study found that the additional accreditation of Magnet status does not lend itself to a statistically more significant level of collegiality amongst nurses and NPs.

This was an interesting finding as collaboration amongst co-workers is fostered by the Magnet culture by engaging staff in joint decision-making between disciplines, team building, and engaging all staff in improving patient care (American Nurses

Credentialing Center [ANCC], 2012). In addition, the Magnet model embraces health care changes and challenges and supports growth and maturation through those changes, such as the movement of NPs into the acute care setting (ANCC, 2012). Therefore, it was anticipated that there would be a difference in the level of collaboration and collegiality in a Magnet designated hospital verses a non-Magnet designated hospital. A study by Hess, DesRoches, Donelan, Norman, and Buerhaus (2011) supports this notion. The authors found that nurses in Magnet and Magnet in-process hospitals rated the quality of relationships between registered nurses (RNs) and advanced practice nurses (APNs) as excellent or very good compared to non-Magnet hospitals (51% for Magnet, 45% for Magnet in-process, and 33% for non-Magnet) (Hess et al., 2011). Another study by Ulrich, Buerhaus, Donelan, Norman, and Dittus (2007), though not examining the nurse-NP relationship specifically, did find that nursing's perception of the nurse-physician relationship in Magnet and Magnet in-process hospitals was slightly higher than those in non-Magnet hospitals (42% Magnet, 45% for Magnet in-process, and 38% for non-Magnet).

The comparison of a Magnet hospital verses a non-Magnet hospital in this study may have been confounded by the significant difference in total results from each institution. Hospital A had a total participation of 162 nurses (73%), whereas Hospital B had a total participation of 60 nurses (27%). This difference in sample sizes may have skewed the data; therefore, more equal sample sizes would be preferred when comparing a Magnet hospital with a non-Magnet hospital.

Additional Data Examination

Collaboration with Nurse Practitioners amongst Different Nursing Positions: Further data analysis was performed to determine whether or not there was any statistical difference between nursing positions held within the acute care setting with regards to the degree of collegiality between nurses and NPs (see Tables 10 and 11). The five positions analyzed were RN staff, RN administration, LPN, NP, and other. No NPs filled out the survey; therefore, no data was available for this group. By far, the majority of responses were completed by registered nurses (n=198). This group reported a mean collaboration score of 36.81 with a standard deviation of 16.03. The next largest group surveyed were RN administrators (n=12). This group reported a mean collaboration score of 40.42 with a standard deviation of 16.19. LPNs were the third largest group (n=7). The mean collaboration score for this group was 31.86 with a standard deviation of 25.06. The final group analyzed was the "other" group (n=5). This group had a mean collaboration score of 39.4 with a standard deviation of 18.56. (see Table 10).

Table 10. Analysis of Collegiality with Nurse Practitioners amongst Different Nursing Positions

	n	Mean	Standard Deviation	95% Confidence Interval for Mean		Min	Max
				Lower Bound	Upper Bound		
RN Staff	198	36.81	16.03	34.56	39.06	0.00	56.0
RN Administration	12	40.42	16.19	30.13	50.71	0.00	56.0
LPN	7	31.86	25.06	8.68	55.03	0.00	56.0
NP	0						
Other	5	39.40	18.56	16.36	62.44	8.0	52.0

Further ANOVA analysis of the data was performed to examine whether or not there was a statistical difference between these different nursing groups (see Table 11). The calculated significance level between groups was 0.721. Therefore, this represents that there is no statistical difference on the mean scale between the before mentioned nursing positions (0.721 > 0.05).

Table 11. ANOVA Analysis of Collegiality with Nurse Practitioners amongst Different Nursing Positions

	Sum of Squares	df	Mean Square	Significance Level
Between Groups	359.33	3	119.78	0.721

The results of this data analysis show that there was no difference in the level of collaboration between different nursing groups and NPs. Again however, there was great variation in the sample sizes; which may account for the no identified difference between groups. The vast majority of respondents were RN staff (n=198, 89.2%). Other nursing groups that were analyzed included: RN administration (n=12, 5.4%), LPN (n=12, 3.2%), and other (n=5, 2.3%).

Reported Known Difference in Practice between NPs and PAs: It is not known why 25.3% of nurses were unaware of the difference in practice between NPs and PAs. This could be from a lack of clarification between the two roles from the employing institutions. One survey participant did add a comment to their survey that said, “We do not work with Nurse Practitioners only PAs.” This participant then crossed out that comment and wrote, “Oops, we have 1 practitioner and I didn’t even know that he wasn’t

a PA." Yet another participant wrote the following comment regarding the difference between NPs and PAs, "PA has better wages and more respect. If I went back to school I would most definitely do PA over NP." Another reason for the unawareness of practice differences could be from a lack of clarification during their nursing educational programs.

Despite the reason why this lack of awareness regarding practice differences between NPs and PAs is occurring; this lack of knowledge poses a significant issue for promoting nurses to pursue advanced practice nursing. Therefore, this incidental finding has the potential to negatively impact future advanced practice nursing. Because of these potential implications it deserves further investigation as to the origins of this practice misunderstanding.

Strengths and Limitations

There has been limited research examining nursing's perspective on the level of collegiality that exists amongst nurses and NPs in the acute care setting. Because of this, a descriptive design was warranted. This descriptive study provides the foundation for which further research can take place. Although identifying the underpinnings of this topic, this study design has the drawback of not identifying the causal linkages between the data and the results, leaving a need for further research.

The sample size utilized in this study was relatively small and is not generalizable to the general nursing population. Additionally, the study was conducted in only one town in the North West, but two relatively large hospitals in were utilized. Therefore, this

sample population of nurses had a greater probability of working with NPs in the acute care setting than those nurses working in smaller hospitals in the North West. This increased the likelihood that these results are representative of the opinions of nurses regarding NPs in the acute care setting. However, the sample sizes from each hospital were not equal (n=162 and n=60). This difference in sample size may have skewed the data when comparing one facility to another. Additionally, of the nurses that were surveyed, the vast majority were RN staff with very few other nursing positions being represented. This large variation in sample sizes may have distorted the data when comparing one nursing position with another.

The CSACD instrument, although reliable and valid, failed to account for those who had not had any interactions with NPs. This was because the CSACD was designed for the nurse-physician relationship. The likelihood that a nurse has worked with a physician in the acute care setting is quite likely; therefore, there was no need to account for interactions that may or may not have occurred. Because the CSACD failed to provide explicit directions for this situation, there were several nurses who indicated that they have never worked with NPs yet they filled out the CSACD questionnaire. This exposed the dilemma of perceived verses actual interactions with NPs. The CSACD did not specifically indicate that only those who have had actual interactions with NPs were to fill out the questionnaire. Therefore, the data from those who had never had interactions with NPs could not be excluded from the data analysis and this may have skewed the data.

An additional limitation for this study was that the demographic survey did not ask how many NPs the nurses worked with. By not asking this question, nursing's opinion of the degree of collaboration could be based on encounter(s) with one NP or many. Thus, a more accurate analysis could have been made had this distinction been identified in the demographic survey.

The majority of the nurses surveyed reported being aware that there was a difference in practice between NPs and physician assistants (PAs) (n=166, 74.8%). However, 56 nurses (25.3%) reported not knowing what the practice difference was between an NP and a PA. This unfamiliarity regarding the practice differences between NPs and PAs could cause some nurses to have unmet expectations or could cause conflict between nurses and NPs. This could result in lower CSACD scores.

Although there are several limitations to this study, this study was the first to examine the perceived level of collegiality by nurses regarding the nurse-NP relationship in the acute care setting. Thus, this study has formed the underpinnings for which additional studies can be designed and conducted. The results of this study indicated that nurses in the acute care setting have a less than collegial relationship with NPs. This highlights the need for hospital administration as well as NPs practicing in the acute care setting to identify and develop ways in which the level of collaboration can be improved and therefore increase nursing and NP satisfaction. This study also identified a gap in nursing's understanding of the scope of practice of NPs. Clarification of the NP scope of practice could lead to greater collaboration scores; and again, greater collegiality and satisfaction amongst nurses and NPs.

This study possessed both strengths and weaknesses. Because this study was the first of its kind, it was expected to have more identifiable weaknesses than those that have been conducted over numerous different studies. However, the identification and acknowledgement of these weaknesses will help to strengthen future studies for an even more accurate examination of the nurse-NP relationship.

Implications for Nursing Practice

The face of health care is changing and with this so too does the face of nursing practice. As NPs extend their practice into the acute care setting, it is imperative that they do so in an effective manner. This shift in traditional acute care structure can cause friction amongst coworkers. To make the movement of NPs into the acute care setting successful, barriers and misperceptions need to be identified. One way to begin exploring this is to assess nursing's general perceptions of the nurse-NP relationship. By identifying nursing's perceptions of the nurse-NP relationship a foundation can be established for which improvements can be fostered.

With increased collaboration comes increased collegiality amongst coworkers, which leads to greater job satisfaction; thus, collaboration is an essential component of the nurse-NP relationship. Awareness of the importance of this can develop and foster improved working environments for both nurses and NPs. This study has modified an existing instrument that can reliably analyze nursing's perceptions of the level of collaboration between nurses and NPs. Use of this instrument will facilitate the identification of needed improvements in the nurse-NP relationship. By strengthening the

nurse-NP relationship a greater level of collegiality can emerge, for which both patients and staff will benefit through; greater nurse retention, improved job satisfaction, and increased respect amongst nurses and NPs to name a few.

An unexpected implication to nursing that this study revealed was the fairly large percentage of nurses who were unaware of the difference in practice between NPs and PAs. This has specific implications to nursing because a lack of understanding of the NP role can be a deterrent to the pursuit of advanced practice nursing. Therefore, nursing institutions need to include education regarding advanced practice nursing to their nursing students in order to make them more aware of the NP role and hopefully encourage them to pursue advanced practice nursing in the future.

Suggestions for Future Research

The nurse-NP relationship has been neglected in previous research studies. Therefore, it is highly encouraged that this area of research be expanded. This study provided some beginning insight into the nurse-NP relationship; however, a more comprehensive knowledge base is needed. It would be beneficial to repeat this study with a larger, more diverse sample and with more equal sample sizes for a more accurate data analysis. The use of the CSACD questionnaire is recommended with the exception of greater specification as to whether or not the responses are based on actual interactions with NPs or perceived interactions with NPs. This is an important distinction as NPs are not as prevalent in the acute care setting as physicians are. Additionally, it would have

been beneficial to add the total number of NPs worked with to the demographic questionnaire. This would allow for more accurate data analysis.

Further expansion of this study with a qualitative study examining the perceived barriers to a collegial nurse-NP relationship with those who expressed a low degree of collaboration would be beneficial. Examination and identification of these barriers would allow for an even greater understanding of the nurse-NP relationship. A better understanding the nurse-NP relationship fosters a greater degree of open communication and effective collaboration, which leads to a greater sense of collegiality, resulting in greater job satisfaction and improved patient outcomes.

An unintended, but nevertheless important finding with this study was the large percentage of nurses who were unaware of the difference in practice between a PA and an NP in the acute care setting. This has significant implications for the future of advanced practice nursing. If nurses are unaware of the scope of practice of NPs, then there is a greater potential for communication breakdown, lack of collaboration, and therefore a lack of collegiality. Additionally, if nurses do not fully understand the role of the NP, then they are less likely to support that role and are less likely to pursue advanced practice nursing themselves.

Both nurses and NPs need to embrace their unique and distinct relationship. As stated in the introduction to this study healthcare is evolving, and strong working relationships amongst health care professionals are needed to survive this turbulent time. As identified by the Thomas conceptual model collaboration, and therefore collegiality, is key to a happy, productive, and successful workforce. However, this does not always

come naturally; therefore, research needs to be conducted to help identify barriers to collaboration. The CSACD questionnaire is a valid and reliable tool that can be used to assess collaboration; however, further research is needed to identify the causal reasons behind low, neutral, and high collaboration scores.

Summary

In summary, this study found a neutral level of collaboration amongst nurses and NPs in the acute care setting. Based on the Thomas conceptual model of collaboration (1976) increasing levels of collaboration are correlated with improved working environment and relationships amongst coworkers. Therefore, a neutral level of collaboration implies a neutral level of collegiality. The nurses utilized in this study perceived a neutral level of collaboration and therefore a neutral level of collegiality regarding the nurse-NP relationship. This study also found no statistical difference between the level of collaboration between a Magnet hospital and a non-Magnet hospital. This indicates that according to the nurses surveyed in this study, there was no higher degree of collegiality amongst nurses and NPs in a Magnet or a non-Magnet facility. Furthermore, this study found no statistically significant difference regarding collaboration, and therefore collegiality, between different nursing groups and NPs. An incidental finding of this study was that a significant portion of nurses were unaware of the difference in practice between NPs and PAs.

REFERENCES CITED

American Academy of Nurse Practitioners (AANP). (2012). Historical Timeline. Retrieved on December 31, 2012 from: http://www.aanp.org/all-about-nps/historical-timeline

American Academy of Nurse Practitioners (AANP). (2010). Nurse Practitioners in Primary Care. Retrieved December 19, 2011 from: http://www.aanp.org/NR/rdonlyres/9AF1A29F-5C82-4151-98CB-22D1F20A9BD9/0/NPsInPrimaryCare324.pdf.

American Academy of Nurse Practitioners (AANP). (2011). Nurse Practitioner Facts. Retrieved on December 19, 2011 from: http://www.aanp.org/NR/rdonlyres/B899F71D-C6EE-4EE6-B3EE-466506DFED60/5145/AANPNPFactsLogo72011.pdf.

American Association of Nurse Practitioners (AANP). (2013). What's an NP? Retrieved on January 4, 2013 from: http://www.aanp.org/all-about-nps/what-is-an-np

American College of Physicians. (2010). Hiring a Physician Assistant or Nurse Practitioner. *American College of Physicians: Center for Practice Improvement & Innovation,* Retrieved on January 23, 2013 from: http://www.acponline.org/running_practice/practice_management/human_resources/panp2.pdf

American Nurses Credentialing Center (ANCC). (2012). Benefits. Retrieved on December 31, 2012 from: http://www.nursecredentialing.org/WhyBecomeMagnet.aspx

American Nurses Credentialing Center (ANCC). (2012). Magnet Recognition Program Model. Retrieved on December 31, 2012 from: http://www.nursecredentialing.org/Magnet/ProgramOverview/New-Magnet-Model

Baggs, J. (1993). Development of an instrument to measure collaboration and satisfaction about care decisions. *Journal of Advanced Nursing,* 20, 176-182.

Bailey, P., Jones, L., & Way, D. (2006). Family physician/nurse practitioner: stories of collaboration. *Journal of Advanced Nursing,* 53(4), 381-391.

Barr, M., Johnston, D., & McConnell, D. (2000). Patient satisfaction with a new nurse practitioner service. *Accident & Emergency Nursing,* 8, 144-147.

Berry, J. (2009). Nurse Practitioner/Patient Communication Styles in Clinical Practice. *The Journal for Nurse Practitioners,* 5 (7), 508-515.

Career Resource Network. (2012). Licensed Practical Nurses. *Research & Analysis Bureau, Montana Department of Labor & Industry,* Retrieved on February 21, 2012 from: http://mcis.dli.mt.gov/licocc_display.asp?id=003-05

Career Resource Network. (2012). Registered Nurses. *Research & Analysis Bureau, Montana Department of Labor & Industry,* Retrieved on February 21, 2012 from: http://mcis.dli.mt.gov/licocc_display.asp?id=003-01

Chaboyer, W., & Patterson, E. (2001). Australian hospital generalist and critical care nurses' perceptions of doctor-nurse collaboration. *Nursing and Health Sciences,* 3, 73-79.

Coeling, H., & Cukr, P. (2000). Communication Styles that Promote Perceptions of Collaboration, Quality, and Nurse Satisfaction. *Journal of Nursing Care Quality,* 14(2), 63-74.

Collins. (2012). Definition of "collegiality." *American English Dictionary,* Retrieved on December 25, 2012 from: http://www.collinsdictionary.com/dictionary/american/collegiality

Crosta, P. (2009). What is Nursing? What Does a Nurse Do? *Medical News Today (MNT),* Retrieved on February 21, 2012 from: http://www.medicalnewstoday.com/articles/147142.php

Dugan, D., Mick, S., Scholle, S., Steidle, E., & Goldberg, D. (2011). The Relationship Between Organizational Culture and Practice Systems in Primary Care. *Journal of Ambulatory Care Management,* 34(1), 47-56.

Fleming, E., & Carberry, M. (2011). Steering a course towards advanced nurse practitioner: a critical care perspective. *British Association of Critical Care Nurses,* 16(2), 67-76.

Fletcher, C., Baker, S., Copeland, L., Reeves, P., Lowery, J. (2007). Nurse Practitioners' and Physicians' Views of NPs as Providers of Primary Care to Veterans. *Journal of Nursing Scholarship,* Fourth Quarter, 358-362.

Frellick, M. (2011). The nurse practitioner will see you now. *Trustee,* May 2011, 8-12.

Gagan, M., & Maybee, P. (2011). Patient satisfaction with Nurse Practitioner care in primary care settings. *Australian Journal of Advanced Nursing,* 28(4), 12-19.

Gair, G., & Hartery, T. (2001). Medical dominance in multidisciplinary teamwork: a case study of discharge decision-making in a geriatric assessment unit. *Journal of Nursing Management,* 9, 3-11.

Gooden, J., & Jackson, E. (2004). Attitudes of Registered Nurses Toward Nurse Practitioners. *Journal of the American Academy of Nurse Practitioners,* 16(8), 360-364.

Health Resources and Services Administration. (2010). The Registered Nurse Population: Initial Finding from the 2008 National Sample Survey of Registered Nurses. *U.S. Department of Health and Human Services,* Retrieved From: http://www.acnpweb.org/files/public/HRSA_2008_Initial_RN_National_Survey.pdf.

Hess, R., DesRoches, C., Donelan, K., Norman, L., & Buerhaus, P. (2011). Perceptions of Nurses in Magnet Hospitals, Non-Magnet Hospitals, and Hospitals Pursuing Magnet Status. *The Journal of Nursing Administration,* 41(7), 315-323.

Kramer, M., & Schmalenberg, C. (2003). Securing "good" Nurse Physician Relationships. *Nursing Management,* 34(7), 34-38.

Lait, J., & Wallace, J. (2002). Stress at Work: A study of Organizational-Professional Conflict and Unmet Expectations. *Industrial Relations,* 57 (3), 463-487.

Lawson, M. (2002). Nurse Practitioner and Physician Communication Styles. *Applied Nursing Research,* 15 (2), 60-66.

Lindeke, L., & Sieckert, A. (2005). Nurse-Physician Workplace Collaboration. *The Online Journal of Issues in Nursing,* 10 (1), Manuscript 4.

Manojlovich, M., & DeCicco, B. (2011). Health Work Environments, Nurse-Physician Communication, and Patients' Outcomes. *American Journal of Critical Care,* 16(6), 536-543.

McMullen, M., Alexander, M., Bourgeois, A., & Goodman, L. (2001). Evaluating a nurse Practitioner Service. *Dimensions of Critical Care Nursing,* 20(5), 30-34.

Rosenstein, A. (2002). Nurse-Physician Relationships: Impact on Nurse Satisfaction and Retention. *The American Journal of Nursing,* 102 (6), 26-34.

Rosenstein, A., & O'Daniel, M. (2005). Disruptive Behavior & Clinical Outcomes: Perceptions of Nurses & Physicians. *The American Journal of Nursing,* 105(1), 54-64.

Shebesta, K., Cook, B., Rickets, C., Schweer, L., Brown, R., Garcia, V., & Falcone, R. (2006). Pediatric Trauma Nurse Practitioners Increased Bedside Nurses' Satisfaction With Pediatric Trauma Patient Care. *Journal of Trauma Nursing,* 13(2), 66-69.

Siegle, D. (2010). Likert Scale. *Neag School of Education – University of Connecticut,* Retrieved on February 20, 2012 from: http://www.gifted.uconn.edu/siegle/research/instrument%20Reliability%20and%20Validity/Likert.html

Speed, S., & Luker, K. (2006). Getting a visit: How district nurses and general practitioners 'organize' each other in primary care. *Sociology of Health & Illness,* 28(7), 883-902.

Taylor-Seehafer, M. (1998). Point of View: Nurse-Physician Collaboration. *Journal of the American Academy of Nurse Practitioners,* 10(9), 387-391.

Thomas, K. (1992). Conflict and conflict management: Reflections and update. *Journal of Organizational Behavior,* 13, 265-274.

Ulrich, B., Buerhaus, P., Donelan, K., Norman, L., & Dittus, R. (2007). Magnet Status and Registered Nurse Views of the Work Environment and Nursing as a Career. *The Journal of Nursing Administration,* 37(5), 212-220.

Weiss, S., & Davis, P. (1985). Validity and Reliability of the Collaborative Practice Scales. *Nursing Research,* 34, 299-305.

Wilson, A., Pearson, D., & Hassey, A. (2002). Barriers to developing the nurse practitioner role in primary care-the CP perspective. *Family Practice,* 19(6), 641-646.

Wilson, K., Coulon, L., Hillege, S., & Swann, W. (2005). Nurse Practitioners' Experiences of Working Collaboratively with General Practitioners and Allied Health Professionals in New South Wales, Australia. *Australian Journal of Advanced Nursing,* 23(2), 22-27.

APPENDICES

APPENDIX A

MONTANA STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD EXEMPT APPROVAL

MONTANA STATE UNIVERSITY

INSTITUTIONAL REVIEW BOARD

For the Protection of Human Subjects
FWA 00000165

960 Technology Blvd. Room 127
c/o Immunology & Infectious Diseases
Montana State University
Bozeman, MT 59718
Telephone: 406-994-6783
FAX: 406-994-4303
E-mail: cheryljj@montana.edu

Chair: Mark Quinn
406-994-5721
mquinn@montana.edu
Administrator:
Cheryl Johnson
406-994-6783
cheryljj@montana.edu

MEMORANDUM

TO: Heather Schroder

FROM: Mark Quinn, Chair Mark Quinn CRJ

DATE: May 9, 2012

RE: *"Collegiality Amongst Nurses and Nurse Practitioners in the Acute Care Setting: A Nurse's Perspective" [HS050912-EX]*

The above research, described in your submission of May 9, 2012, is exempt from the requirement of review by the Institutional Review Board in accordance with the Code of Federal regulations, Part 46, section 101. The specific paragraph which applies to your research is:

___ (b) (1) Research conducted in established or commonly accepted educational settings, involving normal educational practices such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

_X_ (b) (2) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

___ (b) (3) Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

___ (b) (4) Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available, or if the information is recorded by the investigator in such a manner that the subjects cannot be identified, directly or through identifiers linked to the subjects.

___ (b) (5) Research and demonstration projects, which are conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine: (i) public benefit or service programs; (ii) procedures for obtaining benefits or services under those programs; (iii) possible changes in or alternatives to those programs or procedures; or (iv) possible changes in methods or levels of payment for benefits or services under those programs.

___ (b) (6) Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed, or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the FDA, or approved by the EPA, or the Food Safety and Inspection Service of the USDA.

Although review by the Institutional Review Board is not required for the above research, the Committee will be glad to review it. If you wish a review and committee approval, please submit 3 copies of the usual application form and it will be processed by expedited review.

APPENDIX B

SURVEYED CITY'S INSTITUTIONAL REVIEW BOARD EXEMPT APPROVAL

INSTITUTIONAL REVIEW BOARD OF BILLINGS

SERVING
Billings Clinic Montana Cancer Consortium St. Vincent Healthcare Other Independent Investigators & Institutions

May 16, 2012

Heather Schroder
Montana State University-Bozeman
College of Nursing Billings Campus
107 Avenue E
Billings MT 59102

Dear Ms Schroder,

DETERMINATION OF EXEMPTION FROM IRB REVIEW FOR APPROVAL

This letter is issued in response to a university application submission for a graduate nursing research project to conduct an anonymous, written, self-report survey of nurses at Billings Clinic and St Vincent Healthcare.

The IRB of Billings determined using expedited review procedures that the following proposed anonymous survey does not meet criteria for human subjects research and is therefore exempt from prospective IRB review for approval, per 45 CFR 46, section 101 (b)(2):

12.16 (Montana State University – Bozeman/Billings Clinic/St. Vincent Healthcare)
Collegiality Amongst Nurses and Nurse Practitioners in the Acute Care Setting: A Nurse's Perspective

Provide any required IRB of Billings protocol notification to participating sites, oversight authorities, protocol sponsors, or others. Projects exempted by the IRB may be subject to further institutional review.

Sincerely,

James A. Patten, Chairman

Copy: Toni Gauger, Compliance Analyst
Billings Clinic Corporate Compliance *(Required notification for new research at Billings Clinic)*

Jeannine M Brant PhD, Chairman, Nursing Research Council/Inpatient Critical Care,
Billings Clinic *(Required notification for new Nursing Research at Billings Clinic)*

The Institutional Review Board of Billings is in compliance with the regulations of the Food and Drug Administration, effective July 27, 1981, and all amendments thereto, contained in Title 21 of the Code of Federal Regulations, Parts 50 and 56.
The Institutional Review Board of Billings is registered as DHHS OHRP/FDA Nos. IRB00003499 and IORG0002899.

Tel (406) 238-5657 ~ Fax (406) 238-5669
1020 North 27th Street, Suite 120 Billings MT 59101-0760

APPENDIX C

DEMOGRAPHIC QUESTIONNAIRE

Please circle one of the following questions, if you work on multiple units, please circle the unit that you work in the most.

1. How long have you been a nurse?
    a. Less than 1 year
    b. 1-5 years
    c. 5-10 years
    d. Greater than 10 years

2. What area do you currently work in?
    a. Medical
    b. Surgical
    c. ICU
    d. ER
    e. OR/PAT Lab
    f. Oncology
    g. Cardiac/ATU
    h. Psychiatric Center
    i. Family Birth Center
    j. Medical/Oncology

3. What is your area of practice?
    a. RN staff
    b. RN administration
    c. LPN
    d. NP
    e. Other (specify)_____

4. What is the highest level of education that you have complete
    a. Diploma
    b. Associates
    c. Bachelor

d. Master
e. Doctorate

5. How often do you work with a Nurse Practitioner in the Acute Care Setting?
    a. Never
    b. Rarely
    c. Frequently
    d. Very Frequently

6. Which Hospital do you work for?
    a. St Vincent's
    b. Billings Clinic

7. Are you aware of what the difference in practice is between a Physician Assistant and a Nurse Practitioner?
    a. Yes
    b. No

APPENDIX D

COLLABORATION AND SATISFACTION ABOUT CARE DECISIONS (CSACD) QUESTIONNAIRE

For copyright purposes this questionnaire will not be published with this paper. If you wish to use or examine this questionnaire please contact Dr. Judith Baggs who created this instrument.

APPENDIX E

COVER LETTER PROVIDED TO SURVEY PARTICIPANTS

June 2012

Dear Participant,

I am a master's student in the College of Nursing at Montana State University and I am conducting a study regarding the opinions of nurses about the level of collegiality between nurses and nurse practitioners. The objective of this research project is to attempt to understand collegiality amongst nurses and nurse practitioners in the acute care setting. Through your participation, I eventually hope to better understand the relationship between nurses and nurse practitioners.

Enclosed with this letter is a brief questionnaire that asks a variety of questions about your attitudes toward working with nurse practitioners. I am asking you to look over the questionnaire and, if you choose to do so, complete the questionnaire and place it in the provided manila envelope. Return of the survey will be considered consent to use your data in this study.

If you choose to participate, do not write your name on the questionnaire. I do not need to know who you are and no one will know whether you participated in this study. Your responses will not be identified with you personally. Nothing you say on the questionnaire will in any way influence your present or future employment with this organization.

I hope you will take a few minutes to complete this questionnaire. Without the help of people like you, research on employees could not be conducted. Your participation is voluntary and there is no penalty if you do not participate.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me at heather.schroder@montana.edu or my thesis chair Karen Zulkowski at karenz@montana.edu. If you have any questions about your rights as a research subject, you may contact the Montana State University Institutional Review Board (IRB) by mail at P.O. Box 173610, Bozeman, MT 59717-3610, or by phone at (406) 994-6783. This study (IRB #HS050912-EX) was approved by the IRB on May 9, 2012.

Sincerely,
Heather Schroder

Heather Schroder, BSN.
College of Nursing
Montana State University

APPENDIX F

CONSENT FOR USE OF THE CSACD QUESTIONNAIRE BY DR. JUDITH BAGGS

Date: Mon, 30 Apr 2012 12:06:28 -0700
Subject: RE: Permission for Instrument Use – MSU-FNP student

Dear Heather,
You are welcome to use my instrument, the CSACD. I have attached 4 versions, l list of related references, and the original psychometric article.

Best wishes,
Judith Baggs

Judith Gedney Baggs, PhD, RN, FAAN
Elizabeth N. Gray Distinguished Professor
Doctor of Philosophy Program Director
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